*Pathway to achieving the Triple Aim.

DSRIP Journey through the good, the bad and the ugly.



- *Our Hospital
- *Our Team
- *Our Processes





- *Robert Wood Johnson University Hospital is a 965-bed hospital with campuses in New Brunswick and Somerville
- *Robert Wood Johnson Health System is New Jersey's premier health system of choice.
- *Has more than 10,100 employees, 3,250 medical staff members and 1,733 beds.
- *Currently has \$1.5 billion dollars in revenue,





- * Project Champion
- * Project Leader
- * PI coordinator
- * Administrative Assistant
- * Social Worker
- * Pharmacist
- * Dietician
- * Palliative Care
- * Clinical integration
- * Reimbursement
- * IT team
- * Finance team
- * PI team





Members:

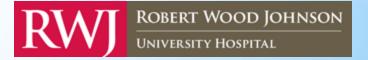
- 1. Project Director: Andrew Thomas
- 2. Director Clinical Integrations: Lois Dornan
- 3. Director Reimbursement: Tina Ford
- 4. PI Coordinator: Augusta Agalaba
- 5. Administrative Assistant: Lilian Folks
- 6. Social Worker: Arianna Illa
- 7. Pharmacist: Laurie Eckert

*Steering Committee



- *Patient Identification
- *Patient Screening
- *Patient Encounter
- *Home Visit
- *Clinic Visit
- *Follow up Phone Calls

*Our Process



- *IT Program identifies and generates a list of all low income patients that hits the ED in the previous 24 hours.
- *List is sorted by Name, MRN, Age, Admit date, Diagnosis, Days since last discharge and payer.
- *List is sent as an email alert to the DSRIP team at 7:05 AM daily.

*Patient Identification



- *APN reviews each patient chart to identify patients to be enrolled in the program.
- 1. Pregnant patients are excluded
- 2. CHF or AMI
- 3. History DM and/or HTN
- 4. History of COPD or Pneumonia
- 5. Patients with LACE Score > 11
- 6. Patients with < 30 days since last discharged

*Patient Screening



- *APN visits each enrolled patient at the bedside to introduce the program, assess social needs and schedule follow up appointment at the Discharge Clinic.
- *Social Worker, Dietician, Pharmacist and Palliative care team are consulted as needed.
- *"Soft medical management" to ensure patient is discharged on the most appropriate medications.

*Patient Encounter



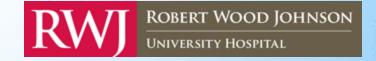
- *AMI and Heart Failure patients are seen at home within 24-48 hours of discharge by an APN.
- *Patients without AMI/HF who are discharged to tertiary care facilities, are seen at that facility within 7 days by an APN.
- *Patients without AMI/HF who cannot afford transportation to the Discharge Clinic are seen by an APN in the home within 7 days.
- *Medication reconciliation
- *Symptom check
- *Patient teaching on diagnosis, red flags and expectations.
- *Scales are provided to HF patients who do not have one.





- *Medication reconciliation
- *Reinforce education on disease processes and Red Flags.
- *Assist with insurance or payer applications.
- *Schedule and establish primary care follow up.
- *Pharmacy and Social needs are addressed on site.
- *Pertinent DSRIP data collected.





- *Follow up visits scheduled for:
 - *BP monitoring
 - *INR monitoring
 - *Lab reviews

*Second Clinic Visit



*Every patient receives three weekly follow up phone calls, starting the week after clinic visit.

*Status update

*Follow up Phone Calls



- *Language Barrier
- *Medication Affordability
- *Homelessness
- *Partnerships





- *Milestones and Timelines
- *Unintentional Paradox
- *The Money
- *Attribution list
- *Attribution list
- *Attribution list





*Future State





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